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No. 98-209

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In The

Supreme Court of the United States

October Term, 1997

PAMELA HERTEL MERS,

Petitioner,

vs.

MARRIOTT INTERNATIONAL GROUP ACCIDENTAL DEATH AND DISMEMBERMENT PLAN,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

RESPONDENT'S BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

This case involves a claim for benefits under an ERISA accidental death plan. Death was due to multiple causes, one of which was strenuous physical activity, while the other was a pre-existing disease (a blood vessel weakened by an aneurysm and/or arterioschlerosis).

I. Should this Court grant certiorari to determine if a summary plan description ("SPD") estops an ERISA plan from enforcing provisions in the underlying plan documents when: (a) below, plaintiff conceded that the SPD contains the "injury" definition she now wants to estop the plan from enforcing, (b) a separate provision in the SPD advises that coverage will be denied whenever "disease of any kind" contributes to death, (c) plaintiff conceded that the SPD's "disease" provision, by itself, can reasonably be interpreted as precluding coverage of her claim, and (d) the alleged circuit "split" only applies to a factual situation not implicated by the present facts — i.e., cases where an SPD is completely silent, not merely ambiguous or less than ideally clear, about a rule or requirement?

II. Should this Court grant certiorari to determine *how much evidence* is needed to establish a conflict of interest when the insurance company that funds an ERISA plan also administers claims under the plan, in a context where the answer makes no difference to the outcome of this case, since the district court applied the legal standard plaintiff advocates and still ruled against her?

STATEMENT PURSUANT TO RULE 29.6

Respondent is Marriott International Group Accidental Death and Dismemberment Plan (the "Plan"). The Plan is an employee benefit plan established under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.* The Plan is not a corporation so it has no "parent companies" and no "nonwholly owned subsidiaries."

The Plan is funded by an insurance policy sold by AIG Life Insurance Company, Inc. ("AIG Life"), a wholly owned subsidiary of American International Group ("AIG"). Neither AIG Life nor AIG is a formal party to this action, although both were named in the complaint.

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INTRODUCTION

This case involves an unsuccessful claim for accidental death benefits under an ERISA plan. Dale Mers was employed by Marriott hotels. On January 5, 1994, during a business trip, he participated in a charitable project that involved using a sledgehammer to tear down a plaster wall. (App. 2). While engaged in this strenuous activity, Mr. Mers complained of chest pains, then collapsed. (*Id.*) The next day he died. The certificate of death states that he died of cardiac arrest, which was due to cerebral hemorrhage resulting from a brain stem infarction. (*Id.*) In plain English, he had a heart attack because a blood vessel in his brain burst. Several other people engaged in the same activity as Mr. Mers, at the same time and place, without suffering any injury. (D. App., p. 4).[1]

Plaintiff, Mr. Mers' widow, filed a claim under the Marriott International Group Accidental Death and Dismemberment Plan ("Plan"). The Plan provides benefits when participants are injured or killed in accidents. The Plan denied this claim for two reasons. The one pertinent here is that Mr. Mers' death was due, at least in part, to a pre-existing condition: a weakened or diseased blood vessel. The Plan is funded by two insurance policies, sold by a subsidiary of American International Group, Inc. ("AIG"). (App. 4-5).

STATEMENT OF THE FACTS

A. The Plan

Marriott's accidental death plan had two components: (1) a "Business Travel" policy, and (2) a "24-Hour" policy. The difference between the two policies is suggested by their

1. "D. App." refers to the separately bound appendix filed by the Defendant in the Court of Appeals.

names: the Business Travel policy only covers accidental losses that occur while someone is traveling on company business (as Mr. Mers was), whereas the 24-Hour policy covers all accidental losses, no matter when they occur.

B. The Plan's Administrative Decision

Plaintiff filed a claim for $100,000 in accidental death benefits.[2] (App. 4). After reviewing the relevant facts and expert medical opinions, the Plan rejected her claim. Under the Plan's terms, a loss is not covered unless it results solely from an accident, without contribution from any other cause (such as a pre-existing condition or disease):

> "Injury" wherever used in this policy means bodily injury *caused by an accident* . . . and resulting directly and *independently of all other causes*. . . .

(App. 4) (emphasis added). The Plan further specifies that there is no coverage for injuries "caused by or resulting from disease of any kind." (App. 3).

The Plan's rationale for denying coverage is straightforward. Everyone agrees that Mr. Mers died because a blood vessel ruptured in his brain. This occurred when his blood pressure rose suddenly due to strenuous physical activity. A healthy vessel could have handled such an increase in pressure. Mr. Mers, however, had a weak vessel — it was clogged, hardened and/or thickened by disease.[3] That is why it burst when

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2. At the administrative stage, she only pursued a claim under the 24-Hour policy.

3. All three doctors agreed on this point. One opined that Mr. Mers had arteriosclerosis. A second doctor opined that he had an aneurysm. The third opined that it was either arteriosclerosis or an aneurysm. (App. 41-42).

the pressure rose. Since it is *undisputed* that this pre-existing condition contributed to his death — every doctor so opined, and plaintiff concedes this point — there is no coverage.

C. Summary Plan Descriptions

A single document serves as a joint Summary Plan Description ("SPD") for both the Business Travel and 24-Hour policies, *and* for three other ERISA plans sponsored by Marriott. This five-part SPD contains a total of 65 numbered pages, a Table of Contents, and a few unnumbered pages at the beginning. (App. 3; D. App., pp. 74-106).

In the margin on the left side of the Table of Contents, the SPD advises that AIG has "sole, absolute and final discretion to construe the terms of the Plan." (App. 47; D. App., p. 77). This applies to both the 24-Hour and Business Travel policies. After that, different portions of the SPD address each policy separately.

24-Hour SPD: This SPD begins by stating that benefits are provided only if an "accidental loss occurs." (D. App., p. 89). It then sets forth a table showing the *types* of losses that may qualify for coverage, and the amount of benefits for each. (D. App., p. 89). Next, the SPD cautions that benefits will not be paid, even when an otherwise qualifying type of loss occurs, if it was "caused by or result[s] from . . . *disease* of any kind." (App. 3; D. App., p. 92) (emphasis added). Finally, page 60 of the SPD states that benefits are payable only "when *injury* results in [a covered] loss." (D. App., p. 101) (emphasis added). Page 60 then provides the same definition of "injury" as the full Plan:

> "Injury" whenever used means bodily injury *caused by an accident* occurring while the policy is in force

> as to the Insured Person and resulting directly and *independently of all other causes* in loss covered by the policy.

(App. 4; D. App., p. 101) (emphasis added).

Business Travel SPD: The SPD for the Business Travel Policy is similar, except it does not contain the definition of "injury." This SPD advises participants that they are covered if certain losses occur "in an accident." (D. App., p. 82). It provides a schedule of benefits, listing the types of "losses" which are covered and the amount of benefits for each. (D. App., p. 82). Finally, it advises there are no benefits when a loss results from "disease of any kind." (App. 3; D. App., p. 83).

REASONS FOR DENYING THE WRIT

I.

PETITIONER'S FIRST THEORY: ESTOPPEL BASED ON THE SPD

Based on a fair reading of the entire Plan, coverage is limited to situations where death results solely from an accident, without significant contribution from a pre-existing condition or disease. The Plan's definition of "injury" requires that an accident, "directly and independently of all other causes," must produce death, while the "disease" exclusion precludes coverage whenever death results from a "disease of any kind." In her appeal to the Seventh Circuit, plaintiff expressly conceded that if one applies these Plan provisions, then she loses: "coverage is . . . not [afforded] under [the] policy definition." (Plaintiff's Appellate Brief, pp. 16-17) (henceforth, "Pltf.'s App. Br.").

To avoid this result, plaintiff argues that the Plan should be estopped from relying on the "injury" definition. The Seventh Circuit rejected her position, reasoning that the plan's definition merely clarifies an ambiguity. Both SPDs state that there is no coverage when death results from "disease of any kind." Below, plaintiff conceded that this provision creates ambiguity about coverage in the present circumstances, where a pre-existing disease was one factor that contributed significantly in causing death. (Pltf.'s App. Br., p. 23) ("the [disease] exclusion can reasonably be interpreted in at least three ways," one of which is that "losses are excluded . . . when they result from disease in any degree whatsoever"). The "injury" definition eliminates any ambiguity, making clear that a loss is not covered unless it results completely independently of disease and other non-accidental causes:

> The problem with this SPD is that it does not explain whether the Plan provides benefits in a situation where there are multiple causes for an accidental death. Both parties agree that multiple reasonable interpretations exist for when an accident triggers coverage; under the language of this SPD, the Plan could require an accident to be the sole cause, the predominant cause, or simply a contributing cause of death. The definition of injury found in the underlying policies resolves this question. The BTA policy defines an injury to mean bodily injury caused by an accident and resulting directly and independently of all other causes. This definition clarifies the question surrounding accidents with multiple causes. Because the definition clarifies and does not contradict the terms of the SPD, Mers cannot estop the Plan from denying coverage based on the clarifying terms of the underlying policies.

(App. 20).

Plaintiff now petitions this Court to grant certiorari to determine if the Plan should be estopped from enforcing the "injury" definition. Specifically, she asserts that the SPD is silent about the Plan's rules in situations where there are multiple causes of death, misleading insureds by promising that benefits will be paid whenever someone dies unexpectedly. This argument is not certworthy for several reasons.

A. Plaintiff Waived This Issue In The District Court.

24-Hour Policy: With respect to the 24-Hour policy, plaintiff's position in the district court was directly contrary to her current theory. In that forum, she confined her estoppel theory to the Business Travel policy, admitting that all provisions of the 24-Hour policy were explained in that plan's SPD. (R. 29, p. 4).

Both the "injury" definition *and* the "disease" exclusion are described in the SPD for the 24-Hour policy. (*Supra*, p. 3). Plaintiff concedes that this SPD fairly explains the "disease" exclusion. In the district court, she made a similar concession about the "injury" definition. She cited page 60 of the SPD, *acknowledged* that the injury provision "is set forth" there, and then limited her estoppel argument solely to the Business Travel policy. (R. 29, p. 4). Only on appeal did she begin arguing that page 60 should not be considered part of the 24-Hour policy's SPD.[4]

Business Travel Policy: Plaintiff failed to exhaust her administrative remedies with respect to a claim under the Business Travel policy; no such claim was presented to the

4. Further, Petitioner tried to deceive the Seventh Circuit. She omitted page 60 of the SPD from the appendix she submitted, then asserted that nothing in the SPD mentions the word "injury." (Supplemental Appendix of Plaintiff-Appellant, pp. 16-42).

Plan for administrative review. The district court declined to dismiss the claim on this ground because, in its view, the two plans were identical in all pertinent respects; hence, requiring formal administrative presentation of a claim under the Business Travel policy would have been futile. (App. 45, 48). Nonetheless, it ruled, alternatively, that if different arguments or considerations would apply to the two plans, then "the Court would dismiss Mers' [Business Travel] claim for her failure to exhaust her administrative remedies"; in that event, "a formal request by Mers to the Plan for benefits under the BTA Policy would not be futile." (App. 48 n.2). Plaintiff did not appeal this provisional ruling. Therefore, she has waived any right to argue, now, that the SPD for the Business Travel policy is less complete than the 24-Hour policy's SPD.

B. The Issue Petitioner Seeks To Raise Is Not Presented By This Case.

According to plaintiff, a circuit split exists on the following issue: when an SPD is completely *silent* about some rule, should an ERISA plan be estopped from using that provision to deny coverage? The facts of this case, however, do not present that question. (*Supra*, p. 3).

Even if one ignores the definition of "injury" found on page 60 of the SPD, the two SPDs would be *ambiguous*, not silent, regarding the causation requirement. Both expressly state that there is no coverage when death results from "disease of any kind." Below, plaintiff conceded that this rule, as described in the SPDs, creates ambiguity about coverage when, as here, death was due to multiple causes. (Pltf.'s App. Br., p. 23) ("the [disease] exclusion can reasonably be interpreted in at least three ways . . .").

C. The Relevant Legal Rule Is Settled — Only A Particular Application Of It Is Disputed.

The fundamental legal principle in this area is settled; at most, there is disagreement about the application of that rule to one particular factual situation. All Circuits, including the Seventh, agree that when an SPD and an underlying policy **contradict** each other, the SPD controls. *E.g., Senkier v. Hartford Life & Accident Ins. Co.*, 948 F.2d 1050, 1051 (7th Cir. 1991) (plan estopped to deny coverage based on policy terms "if there is a *contradiction* between the summary plan document and the policy") (emphasis added); *Martin v. Blue Cross & Blue Shield of Virginia*, 115 F.3d 1201, 1205 (4th Cir) ("if there is a conflict . . . the [SPD] will control"), *cert. denied*, 118 S. Ct. 629 (1997); *Edwards v. State Farm Mutual Auto Ins. Co.*, 851 F.2d 134, 136 (6th Cir. 1988) ("[if] statements in a summary . . . conflict with those in the plan itself, the summary shall govern").

At worst, there may be a narrow dispute about whether a "contradiction" exists in one factual context: when the SPD is silent about an issue, while the underlying plan addresses it, is that a contradiction or merely a clarification? Even on that issue, which is not presented here, the supposed split is not nearly as dramatic as plaintiff claims.[5]

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5. For the most part, the cases plaintiff cites do not address whether an SPD trumps underlying plan documents when the SPD is silent. *E.g., Bartlett v. Martin Marietta Operations Support, Inc. Life Ins. Plan*, 38 F.3d 514 (10th Cir. 1994) (workbook controlled because no other documents existed at time of decedent's death); *Edwards*, 851 F.2d 134 (there was a direct conflict between terms of SPD and terms of Plan regarding whether time on sick leave counted towards length of service); *Genter v. Acme Scale & Supply Co.*, 776 F.2d 1180 (3d Cir. 1985) (past practice, not SPD, controlled where plan did not state that employee could increase his coverage "midstream," but that had been the practice).

D. Adopting Plaintiff's Legal Theory Would Not Change The Outcome Of This Case.

Even were the Plan estopped from applying the "injury" definition, the provision denying coverage whenever a "disease" contributed would still remain. This provision, which appears in both SPDs, is worded broadly; it precludes coverage whenever death resulted from a "disease of any kind." As plaintiff concedes, all three doctors opined that an aneurysm or arterioschlerosis played a significant role in Mr. Mers' death.

E. Ambiguity In An SPD Should Not Preclude Enforcement Of A Plan's Terms.

The view that an ERISA plan's terms may be enforced unless they directly contradict the SPD better achieves ERISA's goals. So long as

> the plan documents do not conflict, the important policy of protecting beneficiaries from misleading or false information contained in a summary plan description is not implicated.

Charter Canyon Treatment Center v. Pool Co., __ F.3d __, 1998 WL 454774, *5 (10th Cir. Aug. 6, 1998).

Adopting a rule that ERISA plans cannot clarify or expand on SPDs would force SPDs to "mushroom in size and complexity until they mirrored the plans." (App. 19). *See also Sprague v. General Motors Corp.*, 133 F.3d 388, 401 (6th Cir.) ("by definition, a summary will not include every detail of the plan it summarizes"), *cert. denied*, 118 S. Ct. 2312 (1998). Such a change in the law "would defeat the [SPD's] function: to provide a capsule guide in simple language for employees." *Herrmann v. Cencom Cable Associates, Inc.*, 978 F.2d 978, 984 (7th Cir. 1992).

II.

PETITIONER'S SECOND ISSUE: INHERENT CONFLICT OF INTEREST.

A. The Legal Rule Is Settled — Only The Amount Of Evidence Required To Establish A "Conflict" Is Disputed.

A decade ago, this Court established the fundamental legal principle regarding conflicts of interest in the ERISA context:

> [I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a "factor in determining whether there is an abuse of discretion."

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). "Since *Firestone*, all of the circuit courts agree that a conflict of interest triggers a less deferential standard of review." *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825 (10th Cir. 1996). The only dispute is whether some courts are "misappl[ying this] properly stated rule of law," *see* S. Ct. R. 10, by requiring *too much or too little evidence* to establish that a "conflict" exists.

Some circuits require nothing beyond the mere fact that an insurance company administers its own plans (i.e., the same company that decides if claims are covered must pay valid claims out of its own coffers); based on that evidence alone, they apply a less deferential standard.[6] Other circuits, including

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6. *E.g., Pitman v. Blue Cross and Blue Shield of Oklahoma*, 24 F.3d 118, 123 (10th Cir. 1994); *Doe v. Group Hosp. & Medical Serv.*, 3 F.3d 80 (4th Cir. 1993); *Brown v. Blue Cross & Blue Shield of Alabama*, 898 F.2d 1556 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991).

the Seventh, require more evidence before they will apply a less deferential standard – some concrete fact which suggests that the people who denied a claim were influenced by their employer's financial stake.[7] *E.g., Farley v. Arkansas Blue Cross and Blue Shield*, 147 F.3d 774, 777 (8th Cir. 1998); *Snow v. Standard Ins. Co.*, 87 F.3d 327, 330 (9th Cir. 1996) (plaintiff must provide "material, probative evidence, beyond the mere fact of apparent conflict, tending to show that the fiduciary's self-interest [actually] caused a breach of the administrator's fiduciary obligations"). This narrow dispute — how much evidence of conflict is needed before a court may accord less deference to a plan's administrative decision — does not warrant this Court's attention.

B. Reaching This Issue Would Not Change The Result In This Case.

Adopting the "inherent conflict" theory would not change the outcome here. The district court *presumed* an inherent conflict, as plaintiff urges, but still found against her:

> [E]ven under a less deferential arbitrary and capricious standard of review that accounts for [the Plan's] inherent conflict of interest, this Court

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7. Contrary to plaintiff's assertion, the Seventh Circuit's approach does not place a "nearly impossible burden" on plan participants to show a conflict. (Petition at p. 27). For example, the Seventh Circuit recently found that a conflict of interest was proved where the company that administered a plan paid bonuses to doctors based on how much money they saved the company by denying claims. *Herdrich v. Pegram*, __ F.3d __, 1998 WL 483926 (7th Cir. August 18, 1998). Likewise, it found sufficient evidence of a conflict when an employer's decision about one particular claim involved an unusually large sum of money and was part of a broader dispute between the company and a union. *Van Boxel v. The Journal Co. Employees' Trust*, 836 F.2d 1048, 1052 (7th Cir. 1987).

> concludes, as a matter of law, that the Plan's determinations (1) that Dale Mers' death was caused, in large part, by a preexisting condition, infirmity or disease (i.e. either an aneurysm or an arteriosclerotic-weakened blood vessel) and (2) that consequently, his death was not covered by the 24-Hour or the BTA Policies were entirely reasonable and appropriate in light of the available medical evidence, the largely undisputed facts, and the relevant judicial precedent.

(App. 59). That result is inevitable, because the Plan's interpretation is entitled to *some* deference, even if one presumes some level of conflict of interest based on the inherent conflict theory. *Firestone*, 489 U.S. at 117 (rejecting argument that *de novo* standard should apply whenever any conflict is established); *Van Boxel v. The Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052 (7th Cir. 1987) (when a conflict of interest is proven, the degree of deference "is a range, not a point"; the more severe the conflict, the less deferential a court will be). Below, plaintiff conceded that the Plan's interpretation was "reasonable." (*Supra*, p. 7). Thus, she cannot prevail under a standard that gives any deference to the Plan's interpretation.

C. The Seventh Circuit's Approach Is Correct.

The Seventh Circuit, along with others, properly declines to hold that an inherent conflict affects every decision made by every insurance company that undertakes the dual roles of deciding and paying claims. The "inherent conflict" theory arguably might fit some other contexts where insurance companies decide claims, but it does not fit here.

In the ERISA context, an insurer does not deal only with unsophisticated, individual consumers. Instead, it deals with

large employers, such as Marriott, who have the bargaining power, knowledge and sophistication to take their business elsewhere if a particular insurer makes a habit of denying valid claims just to save money. Thus, as the Seventh Circuit reasoned:

> [I]t is a poor business decision [for an insurer such as AIG] to resist paying meritorious claims for benefits. Companies like Marriott that sponsor ERISA plans are customers who choose which group insurance plans they will use to fund their plans. Mers and the Plan agree that these employers want to see their employee's claims granted because they want their employees satisfied with their fringe benefits. These corporate employers have the sophistication and bargaining power necessary to take their business elsewhere if an insurer like AIG consistently denied valid claims. In the long run, this type of practice would harm an insurer by inducing current customers to leave and by damaging its chances of acquiring new customers.

(App. 11). The Eighth Circuit, in a recent decision, agreed with the Seventh Circuit's analysis:

> When considered in isolation, an insurer's desire to maintain competitive insurance rates could be construed as a conflict of interest. However, a benefits determination includes equally compelling long-term business concerns that would encourage insurers to make these determinations in a fair and consistent manner, thus negating any indicia of bias. In the long run, an insurer that routinely denies valid claims for benefits would have difficulty retaining current customers and attracting new business.

Farley, 147 F.3d at 777. The approach of the Seventh and Eighth Circuits, which considers the realities of each individual case, instead of adhering to an inflexible presumption in all cases, is superior.

Finally, ERISA expressly provides that the fiduciaries who adjudicate benefit claims *can* be employees of a "party in interest," including an insurer. 29 U.S.C. § 1108(c)(3). This provision is inconsistent with plaintiff's view that employees of an interested party are inherently incapable of making impartial decisions.

CONCLUSION

Neither issue presented by plaintiff warrants Supreme Court review. The petition for certiorari should be denied.

Respectfully submitted,

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